Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

AHMED A KHALIFA MD PA
1415 HIGHWAY 6 SUITE 400-D
SUGARLAND TEXAS 77478

Respondent Name
OLD REPUBLIC INSURANCE CO

Carrier's Austin Representative
Box Number 44

MFDR Tracking Number
M4-12-3303-01

MFDR Date Received
July 9, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the request for reconsideration letter: "Based on this E.O.B. the payment of $452.48 for the procedural code 95903 was denied. The rational for the denial was 'preauthorization absent.' Please note your record as this procedure was pre-authorized on February 29, 2012 (9768837)."

Amount in Dispute: $452.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to the DWC060 request. A copy of the DWC060 was placed in the insurance carriers' representative box 44 on July 9, 2012. The DWC060 was picked up and signed by White Espey on July 17, 2012. The Medical Fee Dispute Resolution section will issue a decision based on the information contained in the file at the time of the audit.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 14, 2012	95903 x 4	$452.48	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline procedures for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 19 – Precertification absent
   - BL – Duplicate denial, for all recon/adjustments/additional pymnt requests. Submit a copy of this EOR or clear notation that a rec

Issues

1. Did the requestor obtain preauthorization for the disputed charge?
2. Did the requestor bill in conflict with the NCCI edits?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor disputes non-payment of CPT code 95903 x 4 rendered on March 14, 2012. The AMA CPT defines code 95903 as "Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study." The requestor indicates in their position summary that preauthorization was obtained under preauthorization # 9768837. The requestor did not include a copy of the preauthorization letter in support that CPT code 95903 was preauthorized as indicated the “Request for Reconsideration” letter. As a result, the division is unable to determine if the disputed CPT code 95903 was preauthorized.
2. 28 Texas Labor Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
    - NCCI edits were run to determine proper reimbursement. The requestor billed the following CPT codes on March 14, 2012; 95903, 95904, 95934, 95861 and 99212. The division identified an NCCI edit conflict which states "Per CCI Guidelines, procedure code 95903 has a CCI conflict with procedure code 95861. A modifier is not allowed. "
3. As a result, the requestor is not entitled to reimbursement for disputed CPT code 95903 x 4 rendered on March 14, 2012.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 26, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.